2017 Open Enrollment Benefits Summary for the State of Kansas

BlueCross BlueShield of Kansas

bcbsks.com

	Cost to member when receiving services from Network providers		Cost to member when receiving services from Non Network providers	
	Plan A	Plan C	Plan A	Plan C
Annual Plan Deductible	Employee only: $1,000 Employee & 1: $2,000 Employee & 2+: $3,000	$2,750 individual/ $5,500 family	Employee only: $1,200 Employee & 1: $2,400 Employee & 2+: $3,600	$2,750 individual/ $5,500 family
Coinsurance For All Eligible Expenses (unless otherwise noted)	20% coinsurance	20% coinsurance	50% coinsurance	50% coinsurance
Annual Out-of-Pocket Maximum (includes deductible, coinsurance and copayment)	$5,750 individual/ $11,500 family combined medical and drug	$5,000 individual/ $10,000 family combined medical and drug	$5,750 individual/ $11,500 family	$5,000 individual/ $10,000 family
Lifetime Benefit Maximum	none		none	

For a complete benefit description, please visit bcbsks.com/customerservice/members/state/index.htm

Note: When receiving services from Non Network providers, you may be responsible for additional out-of-pocket expenses for balances over allowed charges.

Covered Services	Cost to member when receiving services from Network providers		Cost to member when receiving services from Non Network providers	
	Plan A	Plan C	Plan A	Plan C
Preventive Care				
• Well Woman Exam	none		not covered	
• Mammograms	none		deductible plus coinsurance	
• Well Baby and Child Care	none		not covered	
• Well Man Care	none		not covered	
• Routine Vision Exam (refraction for glasses – lenses and frames NOT covered)	none		not covered	
• Routine Hearing Exam (hearing aids NOT covered)	none		not covered	
• Age Appropriate Bone Density Screening	none		not covered	
• Colonoscopy Screening	none		not covered	
• Preventive Lab Services	none		not covered	
Immunizations				
• Pediatric	none		covered in full to age six, otherwise deductible plus coinsurance	
• Adult	none		not covered	
Physician Care				
• Primary Care Physician Office Visits (PCP)	$40 copayment	deductible plus coinsurance	deductible plus coinsurance	
• Specialist Office Visit	$60 copayment	deductible plus coinsurance	deductible plus coinsurance	
Inpatient Services (services must be pre-approved by health plan)				
Services include semi-private hospital room & board, physician and surgeon services, lab, x-ray, anesthesiology and other facility and ancillary charges	deductible plus coinsurance		deductible plus coinsurance	

Covered Services	Cost to member when receiving services from Network providers		Cost to member when receiving services from Non Network providers	
	Plan A	Plan C	Plan A	Plan C
Outpatient Surgery				
• Surgery/Anesthesia/ Assistant Surgeon	deductible plus coinsurance		deductible plus coinsurance	
Outpatient Services				
Not listed elsewhere	deductible plus coinsurance		deductible plus coinsurance	
Outpatient Laboratory Services				
• Preferred lab benefit	no cost to member if using preferred lab vendor	discounts to member if using preferred lab vendor while satisfying deductible – no cost to member if using preferred lab vendor after deductible is satisfied	not available	
• Other labs	deductible plus coinsurance		deductible plus coinsurance	
Urgent Care Facility Visits				
	$50 copay	deductible plus coinsurance	deductible plus coinsurance	
Ambulance/Emergency Transportation (Domestic Ground or Air)				
	deductible plus coinsurance		network deductible plus coinsurance	
Emergency Room Services (copayment waived if admitted to any hospital within 24 hours)				
	$100 copay, deductible plus coinsurance	deductible plus coinsurance	$100 copay, network deductible plus coinsurance	network deductible plus coinsurance
Home Health Care and Hospice Care (services must be pre-approved by health plan – inpatient hospice care is limited to 6 months)				
	deductible plus coinsurance		deductible plus coinsurance	
Rehabilitation Servtices (including physical medicine)				
• Inpatient and Outpatient Facility	deductible plus coinsurance		deductible plus coinsurance	
• Office Services (Office visit copay may apply if an office visit is billed)	deductible plus coinsurance		deductible plus coinsurance	
	spinal manipulations limited to 30 visits per calendar year			
Durable Medical Equipment (DME) (DME greater than $750 must be pre-approved by health plan)				
	deductible plus coinsurance		deductible plus coinsurance	
Prosthetic Devices & Orthopedic Devices (prosthetics greater than $1,000 must be pre-approved by health plan)				
	deductible plus coinsurance		deductible plus coinsurance	
Mental Illness, Alcoholism, Drug Abuse or Substance Abuse				
• Inpatient Services	same as medical		same as medical	
• Outpatient Services	same as medical		same as medical	
• Office Visits	$40 copayment	deductible plus coinsurance	deductible plus coinsurance	
• Group Therapy Sessions	$20 copayment	deductible plus coinsurance	deductible plus coinsurance	
Autism Services (subject to limitations and pre-approval)				
	deductible plus coinsurance		deductible plus coinsurance	
Bariatric Surgery (subject to limitations and pre-approval)				
	deductible plus coinsurance		deductible plus coinsurance	

Please note: Maximum benefit limits do not guarantee that all services will be approved to the maximum number allowed under this plan. Payments that are on a percentage basis will be applied to the contracted allowed amount reimbursed to the provider, if applicable.

For more information or if you have any questions about a covered service or limitation, please call:
291-4185 (in Topeka) **1-800-332-0307** (toll free)

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